STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295079	A. Building B. Wing	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health & Rehabilitation Center	201 Koontz Lane Carson City, NV 89701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48519 Based on clinical record review, interview and document review, the facility failed to prevent resident to resident abuse for 7 of 28 sampled residents (Resident #15, #16, #17, #19, #21, #22, and #28), and failed to prevent employee to resident neglect for 1 of 28 sampled residents (Resident #13). Findings include: A Facility Reported Incident (FRI) final report, dated 05/01/23, documented on 04/24/23, Resident #13 had an unwitnessed fall resulting in a fractured left hip. Resident #13 was not assessed by a nurse or given medical attention until 04/26/23 due to a Hospitality Aide and Certified Nursing Assistant (CNA) not reporting the fall. Resident #13 Resident #13 was admitted on [DATE], with diagnoses including low back pain, unspecified; age-related osteoporosis without current pathological fracture; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; muscle weakness (Generalized); unspecified abnormalities of gait and mobility; repeated falls; and difficulty in walking, not elsewhere specified. A Nursing Progress Note dated 04/26/23, documented Resident #13 complained of left leg pain on 04/26/23, and had an in-house x-ray ordered. The x-ray revealed Resident #13 had a left femoral neck fracture and was transported via Emergency Medical Services (EMS) to the hospital. Resident #13 was hospitalized from 04/26/23 to 04/29/23. A nursing Progress Note dated 05/01/23, documented Resident #13 had a history of placing themselves on the floor to pray. Staff observed Resident #13 sitting on the floor on 04/24/23. A Care Plan dated 01/25/23, documented Resident #13 had a behavior of placing themselves on the floor to pray or lay down and in the event Resident #13 was on the floor, a nurse was to assess Resident #13 prior to getting up. The Pain Level Chart of Resident #13 from 04/24/23 to 04/26/23, when they received medical attention was as follows: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2023
NAME OF PROVIDER OR SUPPLIER Mountain View Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Koontz Lane Carson City, NV 89701	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/23, Resident #13 had a pain level of 2 out of 10. On 04/25/23, Resident #13 had a pain level of 0 out of 10. On 04/26/23, Resident #13 had a pain level of 5 out of 10. On 05/30/23 at 2:01 pm, the Administrator verbalized Resident #13 had recently broken their left hip due to an unwitnessed fall. The Administrator verbalized they did not know Resident #13 had fallen until the facility started their own investigation due to Resident #13 having a left broken hip with unknown origin. The Administrator verbalized a Hospitality Aide and CNA assisted Resident #13 off the floor after the resident had fallen from their bed on 04/24/23. The Hospitality Aide found Resident #13 on the floor and asked a CNA on the unit to assist them with getting Resident #13 back into bed. The Administrator verbalized the Hospitality Aide and CNA did not report the fall to a nurse or any other staff as they believed Resident #13 had put themselves on the floor. Resident #13 had a behavior care planned for placing themselves on the floor and the Administrator verbalized the Hospitality Aide and CNA believed this was what happened. The Administrator verbalized all staff were coached on falls and the process for reporting them. The facility policy titled Resident Fall Response, updated 05/2016, documented residents who have fallen should not be moved and should be assessed by a Licensed Nurse whether there is an obvious injury or not. The facility policy titled Abuse, Corporal Punishment, Involuntary Seclusion, Mistreatment, Neglect, Misappropriation of Resident Property, and Exploitation, updated 09/17, documented residents have the right to receive services necessary to avoid physical harm, pain, mental anguish, or emotional distress. FRI #NV00068460 31739 FRI #NV00068706 documented Resident #14 yelled a profanity and pushed Resident #15 causing the resident to land on the floor. Resident #14 Resident #14 was admitted to the facility on [DATE], with diagnoses including unspecified psychosis, psychotic disorder with delusions, mental disorder, and mood disorder. Resident #15 Resident #15 was admitted to the facility on [DATE], with diagnoses including cerebral palsy and autistic disorder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Progress Note dated 06/02/23, documented Resident #14 was standing by the dining room door when Resident #15 walked up and jiggled the dining room door handle. Resident #14 then yelled a profanity at Resident #15 and with two hands pushed Resident #15 on the shoulder and upper chest area causing Resident #15 to fall to the floor. Resident #15 was assessed for injury with none noted. On 08/30/23 at 4:48 PM, the Director of Nursing (DON) confirmed Resident #14 had pushed Resident #15 causing the resident to fall to the floor without injury. FRI #NV00068728 documented Resident #16 hit Resident #17 after Resident #17 grabbed the back of Resident #16's wheelchair, then Resident #17 hit Resident #16 in the back. Resident #16 Resident #16 was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder, bi-polar type and unspecified intellectually disabilities. Resident #17 Resident #17 was admitted to the facility on [DATE], with diagnoses including dementia, psychotic disturbance and mood disturbance. A Nursing Progress Note dated 06/05/23, documented Resident #17 grabbed Resident #16's wheelchair to propel forward and Resident #16 became agitated and hit Resident #17 on the left shoulder. Then Resident #17 hit Resident #16 with an open hand on the back. The residents were separated and both assessed with no injuries noted. On 08/30/23 at 4:51 PM, the DON confirmed Resident #16 hit Resident #17 in a reaction to grabbing the wheelchair and Resident #17 hit Resident #16 in the back. FRI #NV00068736 documented Resident #18 hit Resident #19 on the cheek and mouth with a closed fist. Resident #18 Resident #18 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, dementia and unspecified psychosis. Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including dementia, psychotic disturbance and mood disturbance. A Nursing Progress Note dated 06/05/23, documented both residents were attending activities in the dining room when Resident #19 attempted to assist Resident #18. Then Resident #18 became agitated and hit Resident #19 with a closed fist to the left side of the cheek and mouth area. Residents were separated immediately. Resident #19 was assessed with no injuries noted. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/30/23 at 4:54 PM, the DON confirmed Resident #18 hit Resident #19 on the cheek and mouth area. The DON verbalized Resident #19 could sometimes agitate other residents and was to be paired with a staff member during activities. FRI #NV00068757 documented Resident #20 swatted Resident #21's hand away and threw a coffee cup containing coffee at Resident #21's chest. Resident #20 Resident #20 was admitted to the facility on [DATE], with diagnoses including dementia, dysphagia and restlessness and agitation. Resident #21 Resident #21 was admitted to the facility on [DATE], with diagnoses including dementia, unspecified psychosis and cognitive communication deficit. An Interdisciplinary Note dated 06/08/23, documented Resident #20 and Resident #21 were holding hands while sitting down when Resident #20 became agitated and swatted Resident #21's hand away. Then Resident #20 picked up a cup containing lukewarm coffee and threw it at Resident #21's chest area. Residents were immediately separated. Resident #21 was assessed for injury or pain with none noted or expressed. On 08/30/23 at 4:57 PM, the DON confirmed Resident #20 swatted Resident #21's hand away and then threw a cup of coffee at Resident #21. FRI #NV00068775 documented Resident #14 yelled at Resident #22 and hit Resident #22 on the arm twice. Resident #14 Resident #14 admitted to the facility on [DATE], with diagnoses including unspecified psychosis, psychotic disorder with delusions, mental disorder, and mood disorder. Resident #22 Resident #22 admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, dementia and mood disorder. A Nursing Progress Note dated 06/09/23, documented Resident #14 was yelling at Resident #22. Resident #14 continued to follow and make comments towards Resident #22 when Resident #14 reached out and slapped Resident #22's arm twice. No injuries were noted. On 08/30/23 at 5:01 PM, the DON confirmed Resident #14 was yelling at Resident #22 and continued to follow and make comments towards Resident #22. Then Resident #14 slapped Resident #22 on the arm twice. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	FRI #NV00069075 documented Resident #28 was attempting to take Resident #16's food tray. When Resident #16 tried to take the tray back, Resident #16 pushed Resident #28 causing the resident to fall to the floor resulting in a small abrasion to the back. Resident #16 Resident #16 was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder, bi-polar type and unspecified intellectually disabilities. Resident #28 Resident #28 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease and unspecified psychosis. A Social Services Note dated 07/27/23, documented Resident #28 was attempting to take Resident #16's food tray while in the dining room. When Resident #16 tried to take the tray back, Resident #16 pushed Resident #28 causing the resident to fall to the floor resulting in a small abrasion to the back. A room change will be done as these residents were roommates. On 08/30/23 at 5:07 PM, the DON confirmed Resident #16 became agitated when Resident #28 tried to take the resident's food tray. Resident #16's reaction was to push Resident #28 causing the resident to fall to the floor. Resident #28 had a small abrasion to the back. The facility policy titled Abuse Prohibition Notification, and Abuse, Corporal Punishment, Involuntary Seclusion, Mistreatment, Neglect, Misappropriation of Resident Property, and Exploitation, dated September 2017, documented residents had the right to be free from abuse, including verbal and physical abuse and the facilities policies and processes were to be implemented so residents were not subjected to abuse by other residents.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on observation, interview, clinical record review and document review, the facility failed to ensure post fall interventions were implemented and followed after a fall in an attempt to prevent future falls for1 of 28 sampled residents (Resident #8). Findings include: Resident #8 Resident #8 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including diffuse traumatic brain injury with loss of consciousness of unspecified duration, subsequent encounter, epilepsy, unspecified, not intractable, without status epilepticus, anoxic brain damage, not elsewhere classified, and conversion disorder with seizures or convulsions. On 05/30/23 at 9:30 AM, a Licensed Practical Nurse (LPN) explained residents who were identified as a fall risk would have fall interventions put in place in an attempt to prevent injuries if a resident had fallen. The interventions could include fall mats on each side of the resident's bed and the resident would be under close supervision to ensure all precautions had been taken. The LPN verbalized Resident #8 was to be on fall precautions after a recent fall. The LPN verbalized Resident #8 had recently slid out of bed and the mattress to the bed was also on the floor alongside the resident. The LPN explained staff could not determine how the resident fell out of bed because the resident could not move on their own and the resident was nonverbal and could not communicate falling out of bed. The LPN verbalized the resident was assessed for injury and sent to the hospital for further evaluation. The hospital had determined Resident #8 had fractured parts of the legs. Nursing Progress Notes dated 04/11/23, documented Resident #8 was found lying on the floor with the mattress from the bed. The resident was assessed and showed no apparent injury. An Interdisciplinary Team (IDT) Fall Review Note dated 04/12/23, documented Resident #8's mattress seemed to be the cause of the fall because the mattress would dip toward the sides, instead of the middle of the bed. As a result, interventions to include a bariatric low air loss mattress with bolsters was put on the resident's bed. A Care Plan initiated on 02/23/20, documented the resident was a high risk for falls and fall mats were to be at the resident's bedside to ensure the resident would be free from injury. On 05/30/23 at 9:52 AM, Resident #8 was sleeping in bed. The resident's bed was placed in the lowest position, however there were no fall mats placed on either side of the bed. (continued on next page)

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	295079	A. Building B. Wing	08/30/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/30/23 at 10:43 AM, the Administrator explained Resident #8 was bed bound and needed assistance with all needs to include fall precautions as a result of a recent fall in the facility. The resident was found on the ground with the mattress by staff. The resident was assessed and determined the resident would need to go to the hospital for further evaluation, a month after the fall. The Administrator verbalized the resident did not show any signs of discomfort, bruising or injuries and was sent to the hospital for a blister on the resident's knee. Once the resident was at the hospital, it was determined the resident had leg fractures. As a precaution, the resident was put on fall precautions to include the bed in the lowest position and fall mats on each side of the bed. The Administrator observed Resident #8 lying in bed and confirmed the resident did not have fall mats on either side of the bed and verbalized if the resident had fallen again, the fall may cause another serious injury as a result of no bed mats next to the bed. On 05/30/23 at 2:29 PM, the Nurse Supervisor verbalized Resident #8 was discovered on the ground by staff, however the assessment of the resident did not determine any injuries sustained by the resident. As a result, fall mats were placed on each side of the bed as a fall precaution. The Nurse Supervisor explained staff read the care plan for Resident #8's roommate and mistakenly put Resident #8's fall mat by the roommate's bed. A facility policy titled Resident Fall Response, last updated December 2016, documented the facility would provide proper interventions after a resident had fallen and staff would observe every shift to ensure fall interventions were actively in place. Complaint #NV00068655

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48519 Based on interview, clinical record review, and document review, the facility failed to ensure a Licensed Nurse provided care for a resident post fall when a Certified Nursing Assistant (CNA) and Hospitality Aide did not notify a Licensed Nurse of a resident's fall to complete an assessment of the resident for 1 of 15 residents (Resident #13). Findings include: A Facility Reported Incident (FRI) final report, dated 05/01/23, documented on 04/24/23, Resident #13 had an unwitnessed fall resulting in a fractured left hip. Resident #13 was not assessed by a nurse or given medical attention until 04/26/23 due to a Hospitality Aide and Certified Nursing Assistant (CNA) not reporting the fall. Resident #13 Resident #13 was admitted on [DATE], with diagnoses including low back pain, unspecified; age-related osteoporosis without current pathological fracture; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; muscle weakness (Generalized); unspecified abnormalities of gait and mobility; repeated falls; and difficulty in walking, not elsewhere specified. A Nursing Progress Note dated 04/26/23, documented Resident #13 complained of left leg pain on 04/26/23, and had an in-house x-ray ordered. The x-ray revealed Resident #13 had a left femoral neck fracture and was transported via Emergency Medical Services (EMS) to the hospital. Resident #13 was hospitalized from 04/26/23 to 04/29/23. An Education/Coaching Form was completed for the Hospitality Aide on 05/01/23. The form explained all resident falls were to be reported to a nurse so they can assess the resident as the Hospitality Aid cannot physically assist any resident. An Education/Coaching Form was completed for the CNA and explained all resident falls were to be reported to a nurse prior to assisting the resident back into bed. A job description for the Hospitality Aide was reviewed with the Hospitality Aide on 05/01/23. The job description explained the Hospitality Aide reports to the Licensed Nurse on the unit and was responsible for: -Answering call lights to assess resident needs, -Providing snacks and fluids to residents, -Serving food to residents during mealtimes, -Cleaning, disinfecting, and changing linens. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/30/23 at 2:01 pm, the facility Administrator verbalized a Hospitality Aide and CNA assisted Resident #13 off the floor after they had fallen from their bed on 04/24/23. The Hospitality Aide found Resident #13 on the floor and asked a CNA on the unit to assist them with getting Resident #13 back into bed. The Administrator verbalized the Hospitality Aide and CNA did not report the fall to a nurse or any other staff. The Administrator also verbalized is was out of the Hospitality Aide's scope of practice to be assisting a resident back into bed. The facility policy titled Resident Fall Response, updated 05/2016, documented residents who have fallen should not be moved and should be assessed by a Licensed Nurse whether there is an obvious injury or not. FRI #NV00068460